

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006546

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 189

FILED MAR 15 1963

Registration District No. 1002

Registrar's No. 1212

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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27022

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2202-1

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176-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 1 year	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 3125 - 6th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLIFTON G. GAINES		4. DATE OF DEATH Month Day Year February 22, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-20-97
9. AGE (last birthday) 66 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION	
11. BIRTHPLACE (City and state or country) Excelsior Springs, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George D. Gaines		13b. MOTHER'S MAIDEN NAME Ida Correll	
14. NAME OF HUSBAND OR WIFE Pearl Gaines		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of) Yes WW I	
16. SOCIAL SECURITY NO.		17. INFORMANT VA Hospital Official Records	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, BILATERAL DUE TO (b) LYMPHOMA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from February 22, 1962 to Feb. 22, 1963 and know the cause of death. Death occurred at 11:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R.H. Owings M.D.		22b. ADDRESS VA Hospital, Kansas City, Mo.	
22c. DATE SIGNED 2-23-63		23a. BURIAL, CREMATION, REMOVAL (Specify) 2-23-63 REMOVAL	
23b. DATE 2-24-63		23c. NAME OF CEMETERY OR CREMATORY UNKNOWN	
23d. LOCATION (City, town, or county) EXCELSIOR SPRINGS, Mo.		23e. FUNERAL DIRECTOR Richard Funeral Home, Excelsior Springs, Mo.	
23f. ADDRESS 2-24-63		25. DATE RECD. BY LOCAL REG. 2-24-63	
26. REGISTRAR'S SIGNATURE Keith Long			

USE BLACK INK
OR
TYPEWRITER RIBBON

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

L. J. Jaxman
Licensed Embalmer No. 4589

Embalmer Springs Mo.
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.